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## Health Insurance Coverage for Older Adults: Implications of a Medicare Buy-In

By Gretchen Jacobson, Karyn Schwartz and Tricia Neuman

More than four million adults ages 55 to 64 were without health insurance coverage in 2008, and that number has likely continued to grow as the recession has worsened in 2009. Few have greater difficulties finding affordable health insurance for themselves than older uninsured adults without access to coverage from employers or public programs, such as Medicare and Medicaid. Those without health insurance often go without needed care – a potentially serious concern for older adults who tend to have more chronic conditions and medical needs than younger adults. Uninsured adults – particularly those approaching age 65 – sometimes defer necessary care until they qualify for Medicare, putting their health at risk and increasing costs to the Medicare program.<sup>1</sup>

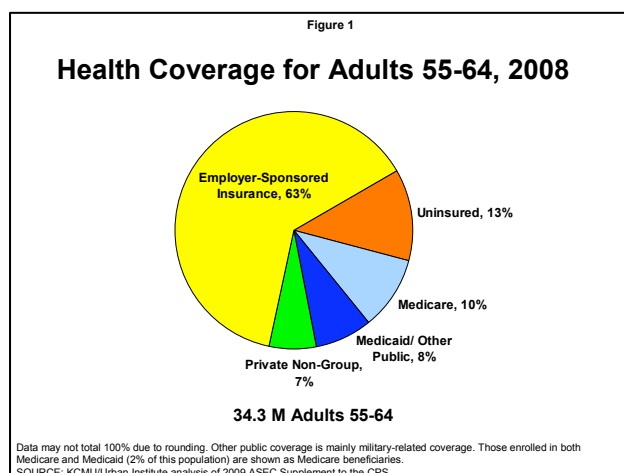
Recently, the idea of a Medicare buy-in has re-emerged in the Senate as a potential component of health reform legislation.<sup>2</sup> To provide information about the population who might be eligible for a Medicare buy-in, this policy brief examines the health insurance status of adults ages 55 to 64, and the characteristics of those who are uninsured. This brief does not analyze the current Senate proposals for a buy-in, since specifications are not yet available. Rather, it describes current sources of health insurance and barriers to securing affordable coverage in the current marketplace and reviews key features of historical Medicare buy-in proposals and the implications of these features for improving health insurance coverage rates among adults ages 55 to 64.

### Health Insurance Coverage

**The majority of adults ages 55 to 64 has employer-sponsored coverage, but about one-in-eight (13 percent) remains uninsured** (Figure 1). Among adults 55 to 64, just seven percent purchases their own insurance in the non-group market. In most states, insurers that sell non-group policies can charge higher premiums based on age and health status, or deny coverage all together, based on an individual's medical history.

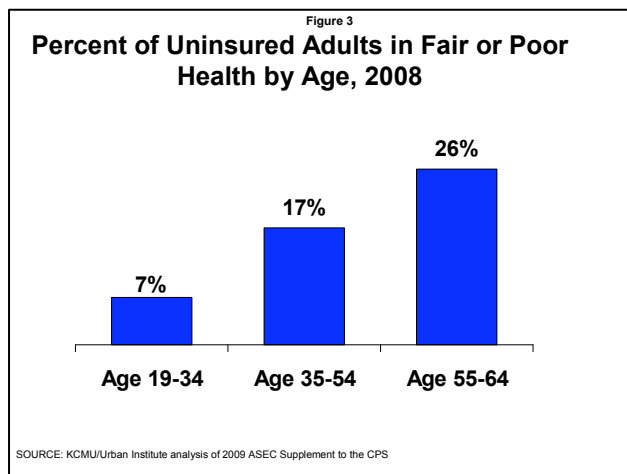
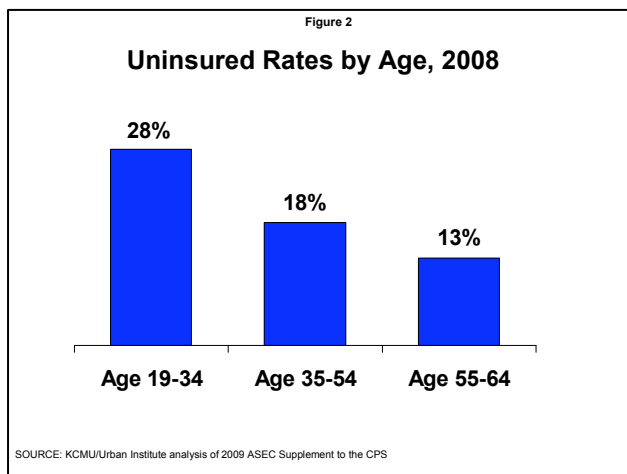
Public coverage, primarily through Medicare and Medicaid, is a source of health insurance for about 18 percent of adults ages 55 to 64 who would otherwise have difficulty gaining private coverage. However, eligibility restrictions for these programs prevent them from reaching many of those who are uninsured. Medicaid eligibility for this age group is generally limited to low-income individuals with disabilities. To be eligible for Medicaid, individuals under age 65 must fall into one of the following groups of low-income individuals: children, parents with dependent children, pregnant women, and people with disabilities. Most states do not offer Medicaid or other public coverage to adults without dependent children regardless of their income.

While Medicare primarily covers adults age 65 and older, almost eight million individuals with disabilities are covered by Medicare, more than three million of whom are between the ages of 55 to 64. In general, people under age 65 who receive Social Security Disability (SSDI) payments typically become eligible for Medicare after a two-year waiting period, while those with end-stage renal disease or Lou Gehrig's disease become eligible for Medicare when they begin receiving SSDI payments. An estimated 30 percent of individuals on SSDI in the Medicare waiting period are uninsured.<sup>3</sup> In 35 states and DC, individuals receiving SSDI payments can "spend down" and become eligible for Medicaid by incurring medical expenses.

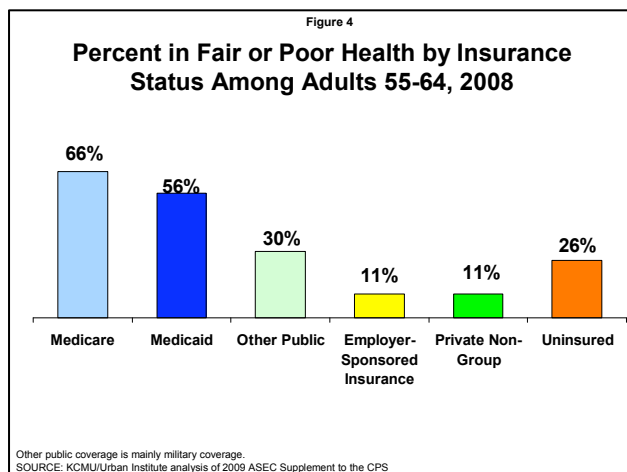


## Health Status

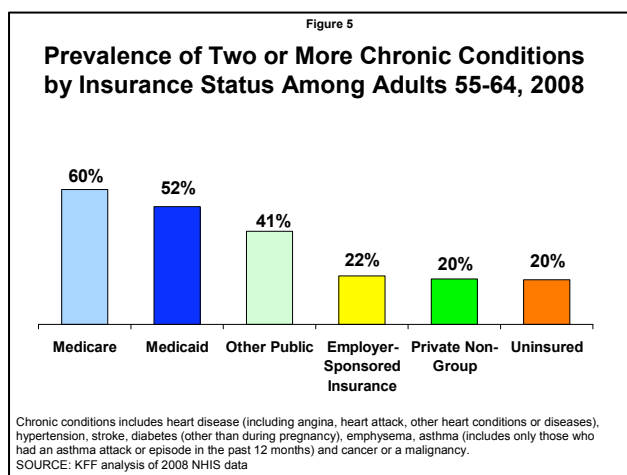
**Uninsured rates decline with age, but the share of uninsured adults in relatively poor health is substantially higher among the older, uninsured population** (Figures 2 and 3). More than a quarter of all adults ages 19-34 are uninsured (28 percent) - more than twice the rate reported among adults ages 55 to 64. Although older adults are less likely to be uninsured, they are *more* likely than younger uninsured adults to have health problems and thus more likely to encounter difficulties finding affordable coverage in the non-group market. While Medicare and Medicaid provide coverage to those with serious disabilities, not all adults with serious health problems qualify for these programs.



**Adults ages 55 to 64 who are uninsured are more than twice as likely to be in fair or poor health than those with private, non-group coverage** (Figure 4). About a quarter of uninsured adults are in fair or poor health. Health problems may limit the ability of uninsured older adults ages 55 to 64 to work in the types of jobs that offer health insurance. Full-time jobs, which may be difficult for those in fair or poor health to maintain, are more likely to provide benefits. In 2009, only 31 percent of firms that offered health benefits extended that offer to part-time workers.<sup>4</sup>



**One-in-five uninsured adults ages 55 to 64 has two or more chronic conditions** (Figure 5). Health insurance is especially important to these adults, since multiple chronic conditions often require ongoing monitoring to prevent declines in health status. Over the past decade, access to care has deteriorated for uninsured individuals with chronic conditions.<sup>5</sup>



## Profile of Uninsured Adults Ages 55 to 64

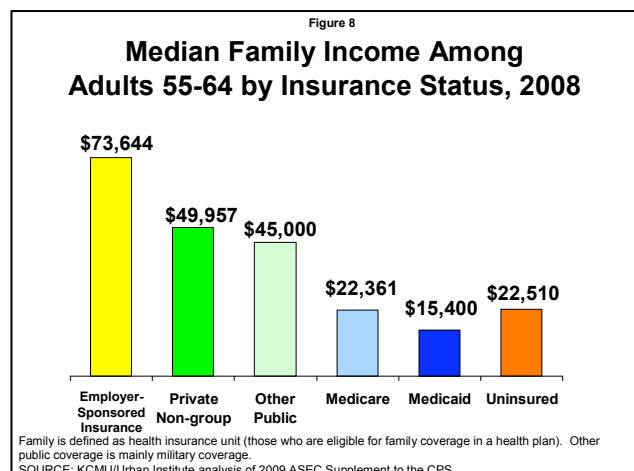
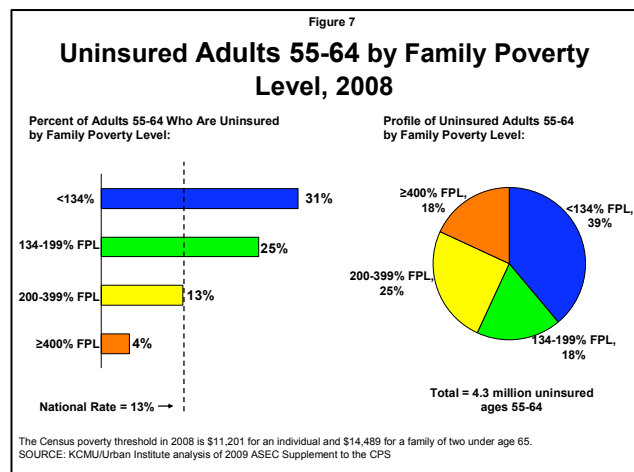
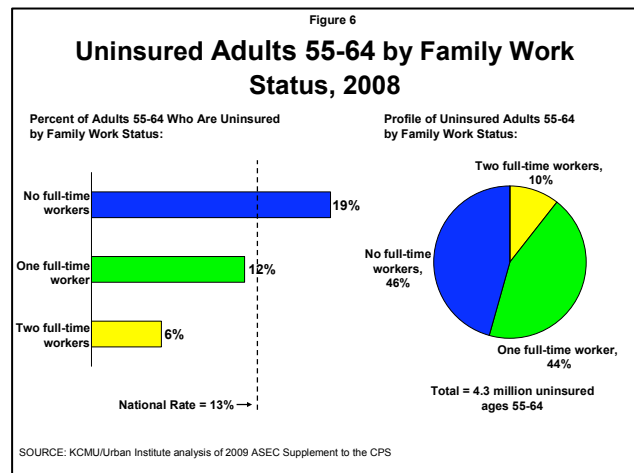
The adults ages 55 to 64 who are most at risk of being uninsured are those with less access to job-based coverage.<sup>6</sup> Coverage rates are highest among those with higher incomes and with full-time workers in the family and lowest for those with low incomes and without full-time workers in the family. Racial and ethnic minorities are also more likely to be uninsured than whites in that age group.

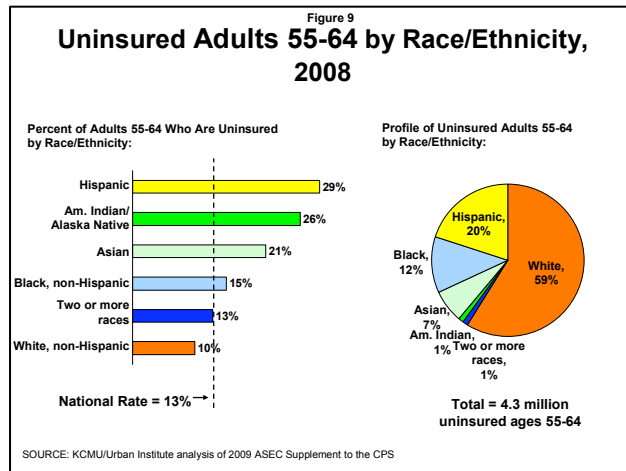
**While adults ages 55 to 64 *without* a full-time worker in their families are more likely to be uninsured than those with a worker, more than half of the uninsured in this age group are from working families** (Figure 6). Older adults in families with two full-time workers are the least likely to be uninsured because they have two potential sources of employer-sponsored coverage and tend to have higher incomes than others. However, with 70 percent of adults ages 55 to 64 in families with a full-time worker, these adults comprise a majority of the uninsured, even though they have a lower than average risk of being uninsured.

**More than half of uninsured adults ages 55 to 64 have incomes below 200 percent of the federal poverty level (about \$29,000 for a family of two in 2008).** The risk of being uninsured increases as family income declines (Figure 7). About one-third (31 percent) of adults between the ages of 55 to 64 with incomes at or below 133 percent of poverty are uninsured. In contrast, just four percent of adults ages 55 to 64 who are in families at or above 400 percent of poverty (about \$58,000 for a family of two in 2008) are uninsured. In the health reform legislation under consideration in the Senate (H.R. 3590), Medicaid coverage would be extended to all adults at or below 133 percent of poverty; the health reform bill passed by the House of Representatives (H.R. 3962) would extend Medicaid to adults below 150 percent of poverty. The House bill's higher Medicaid threshold would cover a slightly greater share (44 percent) of uninsured adults ages 55 to 64 than would be covered through Medicaid under the Senate bill (39 percent).

**Median family income for uninsured adults ages 55 to 64 is \$22,510 in 2008—about \$25,000 lower than for those who purchased their own insurance in the non-group market** (Figure 8). Thus, many uninsured adults would likely have difficulty

affording premiums for private insurance plans and could have trouble paying the required levels of cost sharing even if they could purchase coverage for themselves or their families.



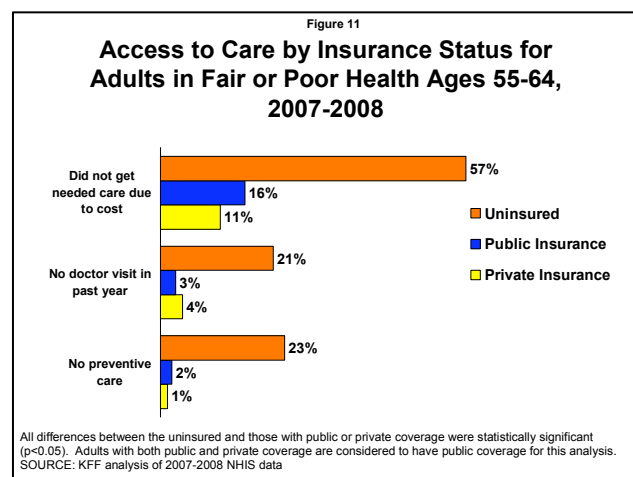
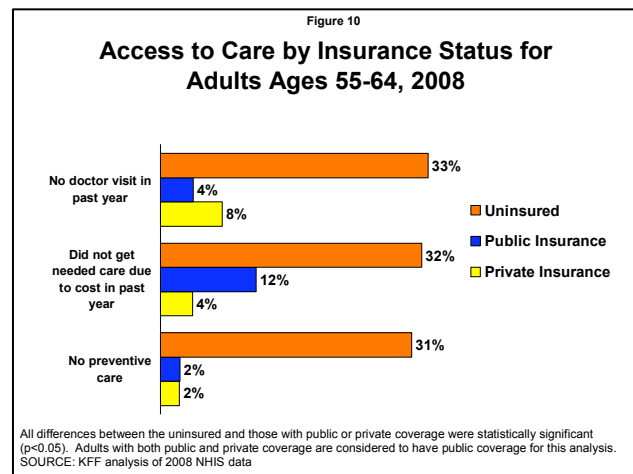


**More than half of uninsured adults ages 55 to 64 are white; uninsured rates are highest among Hispanic adults in this age group.** About three-in-ten Hispanics ages 55 to 64 are uninsured (Figure 9). Racial and ethnic minorities tend to have lower incomes than whites, which may make it more difficult for them to afford health insurance, if they do not have access to employer-sponsored plans and are not eligible for Medicaid or Medicare. Public programs insure 27 percent of blacks and 20 percent of Hispanics ages 55 to 64.<sup>7</sup> Without those programs, uninsured rates for minorities would likely be substantially higher.

## Access to Health Care

**Uninsured adults ages 55 to 64 receive less care and have more problems accessing needed care than those with coverage, similar to uninsured adults in other age groups.** One-third of uninsured adults ages 55 to 64 report that they had not seen a doctor in the past year (Figure 10). Without routine office visits, they risk having health problems go undiagnosed or having symptoms worsen. Almost one-third of uninsured adults ages 55 to 64 say they do not receive preventive care. And, about the same share (32 percent) say that they did not receive needed care due to cost. Research has shown that when the uninsured with cardiovascular disease or diabetes reach age 65 and qualify for Medicare, they are more likely to be hospitalized and have greater health spending than those who were previously insured.<sup>8</sup>

**More than half of uninsured adults ages 55 to 64 who are in fair or poor health did not get needed care in past year due to cost** (Figure 11). More than one-in-five (21 percent) older uninsured adults in fair or poor health had not seen a doctor in the past year. Access to care is similar for those with public and private insurance, and both groups have significantly better access to care than those who are uninsured.



## Current Coverage Options

**About half uninsured adults ages 55 to 64 are working, but many of the working uninsured are not offered coverage through their employers and an additional 30 percent are self-employed** (Figure 12).

Among working adults ages 55 to 64, just 20 percent were offered coverage by their own employer. When adults are not offered employer-sponsored coverage and are not eligible for public coverage, their only option is to try to purchase coverage in the non-group market.

**Medical problems tend to increase with age, making older adults more likely than their younger counterparts to be denied coverage after applying for health insurance in the non-group market.**

Denial rates were more than twice as high for those ages 60 to 64 than for those ages 35-39 (29 percent vs 13 percent, respectively) (Figure 13). Those who were offered coverage may have had to pay for certain services and treatments out-of-pocket because non-group plans often exclude treatment for pre-existing conditions through an elimination rider. In 2009, slightly more than 10 percent of policies offered to adults ages 55 to 64 included such a rider.<sup>9</sup>

Premiums in the non-group market are typically much higher for older adults compared to those who are younger. Annual premiums for an individual between the ages of 55 and 64 averaged \$5,349 in 2009 – almost four times the average annual premium for adults ages 18 to 24 (\$1,429). The average premium for family coverage for adults ages 55 to 64 is \$9,002.<sup>10</sup>

**The average health insurance premium for adults ages 55 to 64 in the non-group market is a substantial share of pre-tax family income for the uninsured.**

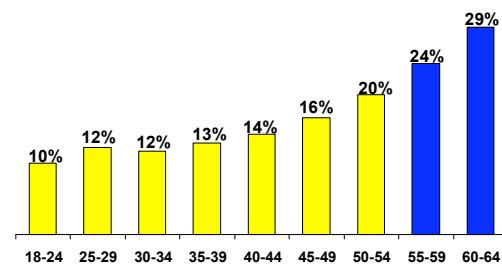
The average individual premium would consume almost a quarter (24 percent) of pre-tax family income; a family premium would consume 40 percent of median family income (Figure 14). The relatively high cost of this coverage makes it unaffordable for most adults ages 55 to 64 without large premium subsidies. Furthermore, because non-group coverage tends to be less comprehensive than employer-sponsored policies, with higher deductibles and other cost sharing than is typical for a large employer-sponsored plan,<sup>11</sup> those who are able to purchase coverage may still incur relatively high out-of-pocket costs, in addition to premiums.

Figure 12  
**Offer of Coverage Among Uninsured Working Adults Ages 55-64, 2008**



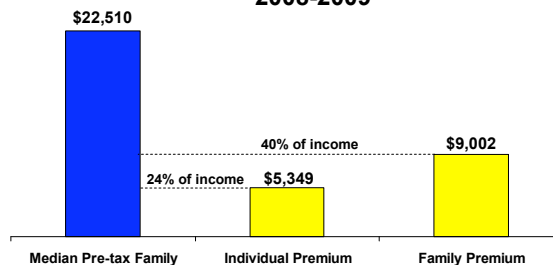
SOURCE: KFF analysis of 2008 NHIS data

Figure 13  
**Denial Rates for Non-Group Coverage by Age Group, 2008**



SOURCE: American's Health Insurance Plans, *Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability and Benefits 2009*.

Figure 14  
**Income for Full-Year Near-Elderly Uninsured Compared to Non-Group Insurance Premiums, 2008-2009**



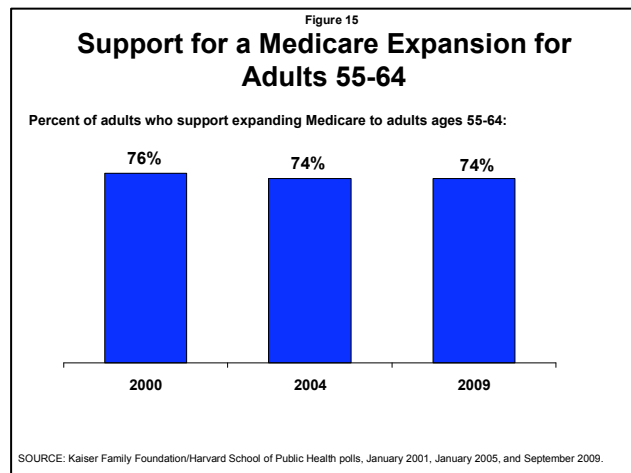
Average premiums are weighted average of premiums for age 55-59 and age 60-64 age groups in 2009. Average family size for family coverage is about 2.4 covered family members.  
SOURCE: Premiums are from American's Health Insurance Plans, *Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability and Benefits 2009*. Income is from KCMU/Urban Institute analysis of 2009 ASEC Supplement to the CPS.



## Overview of Medicare Buy-In Proposals

A Medicare buy-in proposal is one of the many approaches that have been proposed to help uninsured adults ages 55 to 64 gain access to health insurance coverage. A Medicare buy-in could build on the existing Medicare program to offer coverage to those who are now uninsured. Most recently, a Medicare buy-in has been raised in ongoing discussions about health reform legislation in the Senate as another coverage option for the uninsured adults ages 55 to 64 – either on an interim or long-term basis. In the past, others, including the Clinton Administration, proposed a Medicare buy-in as a permanent expansion of the Medicare program.<sup>12</sup>

Polling over the past decade has shown consistent support for expanding Medicare to adults ages 55 to 64 without health insurance. A Medicare expansion for this population is one of many health reform options that are popular with the public.<sup>13</sup> Based on polls conducted in 2000, 2004 and 2009, about three-quarters of adults in the U.S. have said they support this idea (Figure 15). While there has been consistent support for this means of expanding coverage, several key details regarding how an actual buy-in for this group would work would need to be resolved before any such proposal could be implemented. These details could affect public support for the program.



Medicare buy-in proposals differ with respect to a number of key features, including eligibility criteria, premium levels, and subsidies. Decisions about these features have important implications for the number and characteristics of people who would enroll, and for government spending. The following section walks through key features of various Medicare buy-in proposals and discusses their implications for improving coverage rates among uninsured adults ages 55 to 64.

## ELIGIBILITY

A Medicare buy-in is by definition an incremental strategy for increasing health insurance coverage for a specific group of people, and does not aim to provide coverage for all. Buy-in proposals typically restrict eligibility to adults ages 55 to 64, but many further narrow eligibility to a subset of this population. Such restrictions may reflect philosophical views, such as minimizing the reach of a government plan, but may also reflect budget constraints that necessitate limiting the program to those of greatest need. The fewer the eligibility restrictions, the more people would likely be covered by a Medicare buy-in.

In addition to age restrictions, eligibility rules for Medicare buy-in proposals also vary in how they treat active workers or retirees who have access to other sources of coverage, such as an employer-sponsored plan.

**Age.** Medicare buy-in proposals are typically targeted to individuals between the ages of 55 and 64, although eligibility requirements sometimes differ by age within this population. Some proposals, including a recent white paper on health reform, would have uniform eligibility requirements for all within the ages of 55 to 64. Others have proposed stricter eligibility criteria for adults ages 55 to 61 than those ages 62 to 64. For instance, one proposal would limit enrollment among people ages 55 to 61 to those who involuntarily lost their jobs, exhausted COBRA benefits, and were covered by a group health plan for at least the previous 12 months, but would allow all adults ages 62 to 64 to buy into Medicare as long as they did not have access to public or group health insurance.<sup>14</sup>

**Spousal Coverage.** Some proposals would extend eligibility to younger spouses of Medicare beneficiaries – individuals who may have lost access to health insurance when their spouse became eligible for Medicare. In contrast to employer-sponsored coverage, spouses and dependents are not eligible for Medicare until they turn 65, unless they qualify because of a disability. For married couples previously covered under the older spouse's plan, current Medicare eligibility rules could result in the younger spouse becoming uninsured when the older spouse goes on Medicare. Some proposals implicitly include younger spouses by allowing all people ages 55 to 64 without access to health coverage to buy into Medicare. Others would go further and allow spouses of displaced workers ages 55 to 64 to buy into Medicare, even if the spouse is younger than 55.<sup>15</sup>

**Access to Group Health Coverage.** A basic question is whether people with access to group health plans should be allowed to buy into Medicare, and whether employers should be permitted to buy into Medicare on behalf of their older employees or retirees. Employers could yield significant savings if Medicare were to become the primary insurer for their employees or early retirees, but allowing employers to buy into Medicare could shift costs onto the federal government without reducing the number of uninsured, essentially shifting insured older adults from one plan to another.

Most Medicare buy-in proposals would restrict eligibility to those *without* access to a group health plan, either through their employer or spouse. Individuals eligible under such a proposal would include those who are self-employed, employed at a company that does not offer a group health plan, and retirees and unemployed workers who do not have access to retiree health insurance or COBRA.<sup>16</sup> Currently, those without access to a group health plan can only obtain coverage in the non-group market (also known as the individual market), but such coverage is often prohibitively expensive, and often excludes pre-existing conditions. Typically in Medicare buy-in proposals, individuals who do purchase coverage in the non-group market would be permitted to buy into Medicare.

Some have proposed a Medicare buy-in as a way to help employers with the cost of retiree health care by allowing retirees ages 55 to 64 with employment-based retiree health insurance to buy-into Medicare.<sup>17</sup> However, this is not the norm. Most proposals would prohibit employers and workers with employer-sponsored coverage from buying into Medicare – to discourage a further erosion of employer-sponsored insurance, a phenomenon known as crowd-out.

There is some concern that crowd-out may also occur in response to the availability of a Medicare buy-in for adults ages 55 to 64. In order to prevent crowd-out in the group health insurance market, some proposals include a maintenance-of-effort provision, such as requiring employers to contribute to the premium or limiting the extent to which employers could encourage employees to enroll in the buy-in.<sup>18</sup> Another way to prevent crowd-out, albeit one that would increase federal spending, would be to provide a direct subsidy to employers to discourage them from dropping their employer-sponsored benefits. This latter method was employed in the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 to dissuade employers from dropping their employer-sponsored drug benefits for retirees enrolled in Medicare.

**Individuals with Access to COBRA.** Unemployed workers and retirees may have access to their former employer's group health plan under COBRA, although this is usually an expensive option for insurance coverage. COBRA coverage typically requires payment of 102 percent of the premium of the former employer's plan. In 2009, the annual cost of employer-sponsored health insurance averaged \$4,824 for an individual policy and \$13,375 for a family policy.<sup>19</sup> Individuals who leave a job are typically eligible for 18 months of COBRA.<sup>20</sup> A provision in the American Recovery and Reinvestment Act of 2009 has aimed to make COBRA more affordable by providing a nine-month federal subsidy that covers 65% of the COBRA premiums for eligible individuals. However, this program is set to end, and individuals who are laid-off after December 31, 2009 will not be eligible for the subsidy.

Given the relatively high cost and temporary nature of COBRA coverage, a Medicare buy-in could be a more affordable option for this population. Some bills for a Medicare buy-in treat those with

access to coverage under COBRA differently from those without such access. For instance, a bill introduced in the 106<sup>th</sup> Congress would have allowed people ages 62 to 64 to be eligible for the buy-in even if they had *not* exhausted their benefits under COBRA.<sup>21</sup> In more recent bills and proposals, access to coverage under COBRA would disqualify people from being eligible for a Medicare buy-in.

## **PREMIUMS**

The level of the premium would affect both the number and characteristics of people who would choose to enroll in the program, and the cost to the federal government. Proposals that aim to expand access to coverage without increasing the costs to the federal government typically would require individuals to pay the full unsubsidized cost of the premiums.<sup>22</sup> Another approach would be to provide a general subsidy to eligible individuals (or additional subsidies to those with low incomes), reducing costs to the individual but increasing federal expenditures.

In addition to the basic question of affordability, there is some concern that an unsubsidized premium could lead to adverse selection and spiraling premiums over time. Individuals with substantial medical needs would presumably be more likely than others to value health insurance, and choose to buy-into Medicare, even at a relatively high premium, while those who are healthier may elect to forego health insurance or search for lower cost alternatives elsewhere. A subsidized premium would encourage more healthy people to enroll and help minimize adverse selection, but would increase federal spending.

**Budget Neutral.** Budget neutral options, with individuals purchasing coverage at the full actuarial value of the premium with no government subsidy, would likely be prone to adverse selection; sicker people who have the greatest need for health insurance, would be most likely to incur health care costs and disproportionately enroll in the buy-in. This would lead to a situation where the premium increases each year in order to maintain the budget neutrality of the buy-in and cover the expected costs. As premiums increase, only the sickest of the sick would be willing to enroll in the buy-in, which in turn would require the premium to increase again to cover the costs of the sickest of the sick. This spiraling upwards of premiums is one of the by-products of adverse selection, and could occur if a premium is not subsidized.

Proposals and bills for a Medicare buy-in have used different budget neutral methods for setting the premium. Some bills<sup>23</sup> set the premium equal to the average annual cost of Medicare for the buy-in population. Other bills have varied the premiums by age and geography.<sup>24</sup> Less recent bills,<sup>25</sup> including the Clinton Administration proposal, would have lowered the buy-in premium below the budget neutral cost for those ages 55 to 64 but would have recouped costs by requiring some enrollees to pay an extra monthly amount beginning at the age of 65.

**Subsidies.** Premium subsidies would help to make premiums more affordable, encourage healthier people to enroll, and mitigate adverse selection; however, subsidies also increase Medicare spending. Premium subsidies could be provided directly through the federal government in the form of lower premium amounts, or indirectly through tax credits.<sup>26</sup> Researchers have tried to quantify the effect of subsidies on the number of people who choose to purchase health insurance coverage, also known as the price-elasticity of insurance coverage.<sup>27</sup> A 2002 analysis estimated that a Medicare buy-in would increase coverage rates for those with health problems, but the overall effect of an unsubsidized buy-in on the uninsured would be fairly small.<sup>28</sup> The analysis found that, without subsidies, the number of uninsured adults ages 55 to 64 would decline from about 10 percent to 9 percent; take-up rates under an unsubsidized Medicare buy-in would be higher among those dropping their relatively expensive private non-group coverage. If Medicare buy-in premiums were subsidized, with more generous subsidies provided to those with low incomes, the share of uninsured adults ages 55 to 64 would decline by nearly half, from 10 percent to 6 percent.



The Congressional Budget Office (CBO) studied the effect of subsidies on the total uninsured population, including those younger than 55, and estimated that a large subsidy would be required to encourage many additional people to enroll. Specifically, CBO estimated that if a non-group premium was reduced through subsidies by 25 percent, then the number of people enrolled would increase by 2 to 6 percent. If the premium was reduced by 50 percent, then the number enrolled would increase by 4 to 20 percent.<sup>29</sup> CBO also noted that the subsidies would be more likely to induce participation among higher income than lower income people; that is, the impact of the subsidy would decrease as income per eligible person decreased and lower-income people would need a larger subsidy to induce them to enroll.<sup>30</sup> In effect, subsidies may be necessary to encourage healthier people and those with low incomes to enroll in a Medicare buy-in. An important caveat, however, is that these estimates looked at a Medicare buy-in by itself and not in conjunction with other more comprehensive health reform proposals.

## CONCLUSION

More than four million adults ages 55 to 64 lack health insurance. Uninsured adults ages 55-64 face both higher premiums and higher denial rates in the individual market than younger uninsured adults. Uninsured 55 to 64 year olds have lower incomes, are in poorer health and have greater difficulty getting needed medical care than their insured counterparts. A Medicare buy-in has the potential to bridge the gap for those without access to other sources of affordable coverage, and the design of such a buy-in will affect the number of people likely to enroll and the impact on Medicare spending. Given modest incomes of many uninsured older adults, few would be able to purchase Medicare coverage without fairly substantial subsidies. In the context of the current debate, a Medicare buy-in could provide coverage in a relatively short period of time, as early as 2011, and target help to those who are most likely to have difficulty purchasing coverage on their own in the individual market. If implemented in conjunction with other health reforms, key considerations include the extent to which Medicare premiums are subsidized, whether Medicare premiums for older adults are higher or lower than those of private insurers, whether older adults are required to have health coverage through an individual mandate, and the relative generosity of Medicare benefits relative to benefits offered by private plans.

<sup>1</sup> J.M. McWilliams et al., "Impact of Medicare Coverage on Basic Clinical Services for Previously Uninsured Adults," *JAMA*, vol. 290, no. 6 (2003), p. 757-764. Also see J.M. McWilliams et al., "Health Insurance Coverage and Mortality Among the Near-Elderly," *Health Affairs*, vol. 23, no. 4 (2004), p. 23-233.

<sup>2</sup> Greg Hitt and Janet Adamy, "Senate Turns to Medicare, Medicaid: Democrats Weigh Health Compromise That Would Expand Programs; Scaled-Back Public Plan Gains Fans," *Wall Street Journal*, December 8, 2009.

<sup>3</sup> G. Riley "Health Insurance and Access to Care among Social Security Disability Insurance During the Medicare Waiting Period," *Inquiry*, vol.43, 2006.

<sup>4</sup> Kaiser Family Foundation and Health Research & Educational Trust. *2009 Kaiser/HRET Employer Health Benefits Survey*. 2009 (#7936).

<sup>5</sup> C. Hoffman and K. Schwartz, "Eroding Access Among Nonelderly U.S. Adults with Chronic Conditions: Ten Years of Change," *Health Affairs*, vol. 27, no. 5 (2008), w340-w348.

<sup>6</sup> Details on uninsured rates for adults ages 55 to 64 and a profile of uninsured adults ages 55 to 64 are available in an appendix table.

<sup>7</sup> Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of CPS data.

<sup>8</sup> J.M. McWilliams, et al. "Use of Health Services by Previously Uninsured Medicare Beneficiaries." *New England Journal of Medicine*. 357(2) 2007.

<sup>9</sup> America's Health Insurance Plans, *Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability and Benefits* 2009.

<sup>10</sup> America's Health Insurance Plans, *Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability and Benefits* 2009.

<sup>11</sup> K. Schwartz, G. Claxton, K. Martin and C. Schmidt, "Spending to Survive: Cancer Patients Confront Holes in the Health Insurance System," Kaiser Family Foundation and American Cancer Society (February 2009). (#7851)

<sup>12</sup> For President Clinton's State of the Union addresses in which he proposed a Medicare buy-in, see J. T. Woolley and G. Peters, *The American Presidency Project*. Santa Barbara, CA: University of California. Available at: <http://www.presidency.ucsb.edu/ws/?pid=56280>.

<sup>13</sup> "Kaiser Health Tracking Poll: September 2009," Kaiser Family Foundation, published September 2009; "Health Care Agenda for the New Congress," Kaiser Family Foundation/Harvard School of Public Health, published January 2005; "The Post-Election Survey: The Public and the Health Care Agenda for the New Administration and Congress," Kaiser Family Foundation/Harvard School of Public Health, published January 2001.

<sup>14</sup> See for example, H.R. 3470, sponsored by Congressman Pete Stark in the 105<sup>th</sup> Congress.

<sup>15</sup> See for example, H.R. 2228 sponsored by Congressman Pete Stark in the 106<sup>th</sup> Congress.

<sup>16</sup> For example, see Senator Baucus's "Call to Action: Health Reform 2009."

<sup>17</sup> See S. 3710 sponsored by Senator Rockefeller in the 110<sup>th</sup> Congress and H.R. 2072 sponsored by Congressman Stark in the 109<sup>th</sup> Congress. See also R. Emanuel and B. Reed, "Before We're 64," *Washington Post*, November 5, 2007; p. A19.

<sup>18</sup> See S. 3710 sponsored by Senator Rockefeller in the 110<sup>th</sup> Congress and H.R. 2072 sponsored by Congressman Stark in the 109<sup>th</sup> Congress. In these bills, employers would only be allowed to provide supplemental coverage for services not provided by Medicare and could pay for up to 25% of the premium.

<sup>19</sup> Kaiser Family Foundation and Health Research & Educational Trust. *2009 Kaiser/HRET Employer Health Benefits Survey*, 2009 (#7936).

<sup>20</sup> Those with disabilities may qualify for additional months of COBRA coverage.

<sup>21</sup> See H.R. 2228 sponsored by Congressman Pete Stark in the 106<sup>th</sup> Congress.

<sup>22</sup> See M. Baucus, "Call to Action: Health Reform 2009," November 12, 2008.

<sup>23</sup> For example, see S. 3710 sponsored by Senator Rockefeller in the 110<sup>th</sup> Congress.

<sup>24</sup> For example, see H.R. 3470 and H.R. 4799, both in the 105<sup>th</sup> Congress.

<sup>25</sup> For example, see S. 202 sponsored by Senator Moynihan in the 106<sup>th</sup> Congress.

<sup>26</sup> See for example, S. 3710 in the 110<sup>th</sup> Congress, which included a tax credit for 75% of the buy-in premium.

<sup>27</sup> T.C. Buchmueller, "Consumer Demand for Health Insurance," National Bureau of Economic Research, Research Summary, Summer 2006 [<http://www.nber.org/reporter/summer06/buchmueller.html>].

<sup>28</sup> R.W. Johnson, M. Moon, and A.J. Davidoff, "A Medicare Buy-In for the Near-Elderly: Design Issues and Potential Effects on Coverage," February 2002. Available at [<http://www.kff.org/uninsured/6009-index.cfm>].

<sup>29</sup> Congressional Budget Office, "CBO's Health Insurance Simulation Model: A Technical Description," October 2007.

<sup>30</sup> See, for example H.R. 4799, which included a low-income subsidy for individuals buying into Medicare with incomes less than 200% of the federal poverty level, in the 105th Congress.

**Appendix**  
**Uninsured Adults Ages 55 to 64, 2008**

	All Adults 55-64 (millions)	Percent of All Adults 55-64	Uninsured Adults 55-64 (millions)	Percent of Uninsured Adults 55-64	Uninsured Rate for Adults 55-64
<b>Total - Adults Ages 55 to 64</b>	<b>34.3</b>	<b>100.0%</b>	<b>4.3</b>	<b>100.0%</b>	<b>13%</b>
<b>Family Poverty Level<sup>1</sup></b>					
<134%	5.4	16%	1.7	39%	31%
134-199%	3.1	9%	0.8	18%	25%
200-399%	8.5	25%	1.1	25%	13%
400%+	17.2	50%	0.8	18%	4%
<b>Family Income</b>					
<\$20,000	6.3	18%	1.9	44%	30%
\$20,000 - \$39,999	6.5	19%	1.2	28%	19%
\$40,000 - \$59,999	5.5	16%	0.5	12%	9%
\$60,000 +	16.0	47%	0.7	16%	4%
<b>Family Work Status</b>					
Two full-time workers	8.2	24%	0.5	10%	6%
One full-time worker	15.7	46%	1.9	44%	12%
Part-time worker	3.1	9%	0.6	15%	21%
No workers	7.3	21%	1.3	31%	18%
<b>Education</b>					
Less than high school	3.8	11%	1.0	23%	27%
High school graduate	10.4	30%	1.5	35%	15%
Some college/Assoc. degree	9.3	27%	1.0	23%	11%
College grad or greater	10.9	32%	0.8	18%	7%
<b>Gender</b>					
Male	16.5	48%	2.1	49%	13%
Female	17.8	52%	2.2	51%	12%
<b>Age</b>					
Age 55-59	18.7	55%	2.4	57%	13%
Age 60-64	15.5	45%	1.9	43%	12%
<b>Marital Status</b>					
Married	23.8	69%	2.3	53%	10%
Not married	10.5	31%	2.0	47%	19%
<b>Parent Status</b>					
Has dependent children	2.6	8%	0.3	7%	12%
No dependent children	31.7	92%	4.0	93%	13%
<b>Race/Ethnicity</b>					
White only (non-Hispanic)	26.0	76%	2.5	59%	10%
Black only (non-Hispanic)	3.5	10%	0.5	12%	15%
Hispanic	3.0	9%	0.9	20%	29%
Asian/S. Pacific Islander	1.4	4%	0.3	7%	21%
Am. Indian/Alaska Native	0.2	1%	0.0	1%	26%
Two or More Races	0.3	1%	0.0	1%	13%

Source: KCMU/Urban Institute analysis of 2009 ASEC Supplement to the CPS

<sup>1</sup> The Census poverty threshold in 2008 is \$11,201 for an individual and \$14,489 for a family of two under age 65. The term family as used in family income and family poverty level is defined as a health insurance unit (those who are eligible as a group for "family" coverage in a health plan).

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